Exhibit 4

From: [redacted]
To:
Sent: 4/23/2018 7:41:54 PM
Subject: Re: G&R Getting Started
Attachments: BMLL Election Form - [redacted].pdf

Hey [redacted]
Looking forward to working with the firm.
I have attached the employee election form and the W-4 Form.
Let me know if there is any more information you need.
Also please let me know the next steps I need to take.

Thank you,
[redacted]

On Apr 20, 2018, at 11:53 AM, [redacted] wrote:

Hi [redacted]

Welcome to the firm! I'm the office manager at G&R, and you should feel free to get in touch with me over any questions you may have. First things first, I need you to fill out a form W-4 so we can get you onto payroll. Please scan and return it to me after you've filled it out at this email address or fax to [redacted]

Attached are some docs about the health plan (the SBC is the medical benefit summary, the SUM has more detail about the medical plan, then also a dental summary). If you want to get on the firm's health care plan you would be eligible on your date of hire. You would have 30 days from the date of hire to submit the new hire enrollment form, but keep in mind that medical and dental benefits are effective as of the date of hire. If you want to enroll in the healthcare plan please fill out the **BMLL Election Form**.

You are also eligible to participate in our FSA, which is the last pdf there. This is pre-tax money that you can spend on health costs not covered by our general health plan (most of us who use it do so for vision). You don't have to enroll in our general plan to enroll in that. Let me know if you're interested and I'll tell you what the maximum 2018 contribution will be for you, since it will be prorated.

We also have a retirement plan. Let me know if you're interested and I will pass along some info.

Please feel free to get in touch if any questions may arise.

Best,
[redacted]

BenefitMall
All together, better.℠

[redacted]

EMPLOYEE ELECTION FORM

THIS IS NOT AN APPLICATION FOR INSURANCE

BMLL Billing # _____
Effective Date _____
Team # _____
Carrier Group # (See Coverage Boxes)
Employer with 20 or more employees? ☐ Yes ☐ No

☑ New Hire ☐ Re-Hire ☐ COBRA/Continuation (Group Administered) ☐ Add Coverage

Last Name [redacted]	First Name [redacted]	M.I. [redacted]	Employer Goldstein and Russell
Street Address 4151 Via Marina Apt 213			Social Security Number [redacted]
City [redacted]	State [redacted]	Zip [redacted]	Gender ☐ Male ☑ Female / Date of Birth [redacted]
Home Telephone # [redacted]	Business Telephone # ( )	Marital Status ☑ S ☐ M ☐ D ☐ W	Date of Marriage / Full-Time/Re-Hire Employment Date:
Employee Email [redacted]			Payroll Mode (weekly, bi-weekly, etc)
Are you actively working for the employer listed above (as defined in your insurance contract)? ☐ Yes ☑ No ☐ Full-time ☐ Part-time			Hours Worked/Week
Occupation Research	Employee Class	☐ Smoker ☑ Non-Smoker	Annual Salary/Hourly Wage

MEDICAL PLAN (if offered) [1]
Carrier _____
Plan Type _____
Carrier Group # _____
☑ Employee Only
☐ Employee & Spouse
☐ Employee / Child(ren)
☐ Family
☐ Over 65 ☐Retired ☐Working
☐ Medicare or Complimentary to Medicare (CareFirst-Individual only; and benefit coverage only. Not eligible for HSA)
☐ Waive Coverage*

DENTAL PLAN (if offered)
Carrier _____
Plan Type _____
Carrier Group # _____
☑ Employee Only
☐ Employee & Spouse
☐ Employee / Child(ren)
☐ Family
☐ Waive Coverage*

** If enrolling in a DHMO dental plan, please complete provider information below.

VISION PLAN (if offered)
Carrier _____
Carrier Group # _____
☑ Employee Only
☐ Employee & Spouse
☐ Employee / Child(ren)
☐ Family
☐ Waive Coverage*

☐ LTD (if offered) ☐ Waive Coverage*
☐ VOL. LTD ☐ Waive Coverage*
Carrier _____
Benefit $ _____/Mo

☐ LIFE AND AD&D (if offered)
☐ Waive Coverage*
☐ VOL LIFE $ _____
☐ SPOUSE $ _____
☐ DEP. CHILD $ _____
Carrier _____

☐ STD (if offered) ☐ Waive Coverage*
☐ VOL. STD ☐ Waive Coverage*
Plan # _____
Benefit $ _____/ Wk.
Carrier _____

*Waiver of Coverage: I certify that group insurance coverage has been offered to me and I choose to waive coverage due to:
☐ Spousal/Partner Coverage ☐ Parent Coverage ☐ Individual Coverage on Exchange ☐ Individual Coverage off Exchange ☐ Military/VA Coverage ☐ Retiree Coverage ☐ COBRA/Continuation ☐ Medicare/Medicaid ☐ No Coverage ☐ Other _____

[1]If enrolling in HMO coverage, please refer to the "Waiver of Insurance Coverage" included with this form. *By checking "Waive Coverage" you confirm that you waive coverage and have read and understand the "Waiver of Insurance Coverage" information included.

Life Insurance Beneficiary (if coverage offered) **Relationship**

Last, Full First, M.I.	Social Security Number	Birth Date	Sex	Student (Y/N)	Disabled (Y/N)	For HMO, POS, Opt-Out and Dental (if offered) Plans: Primary Care Provider Name and Carrier Assigned Provider #	Existing Patient (Y/N)
Emp [redacted]	[redacted] ☐ Smoker ☑ Non-Smoker	[redacted]	F	N	N	Medical / Dental	
Sp	☐ Smoker ☐ Non-Smoker					Medical / Dental	
Chd	☐ Smoker ☐ Non-Smoker					Medical / Dental	
Chd	☐ Smoker ☐ Non-Smoker					Medical / Dental	
Chd	☐ Smoker ☐ Non-Smoker					Medical / Dental	

OTHER/PRIOR HEALTH INSURANCE: Please note: You must complete this section if waiving or enrolling in medical coverage and your company offers Dual Coverage OR if you are currently covered under Medicare. **DC/VA GROUP COVERAGE: FOR COORDINATION OF BENEFITS, PRIOR COVERAGE INFORMATION MUST BE COMPLETED

Do you or your dependents have other/prior Health coverage with another insurer? ☐No ☐ Yes Dental? ☐No ☐ Yes *If Yes*: Effective Date:_____
☐Other ☐ Prior (indicate one or both) Carrier Name_____Policy #_____
Will this coverage be continued? ☐ Yes ☐ No *If No*: Term. Date: _____
Are you covered by Medicare? ☐No ☐ Yes Effective Date (Part A) __/__/__ Effective Date (Part B) __/__/__ Medicare #_____
Is your spouse or dependent(s) covered by Medicare? ☐ No ☐ Yes Effective Date (Part A) __/__/__ Effective Date (Part B) __/__/__
Name of spouse or dependent(s) covered (if applicable): _____ Medicare #_____

CERTIFICATION: I hereby certify that I am the spouse, parent or legal guardian of the dependent(s) shown above. ***Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.***

- **Voluntary benefits may be subject to pre-existing condition exclusions (please refer to your policy for more information).**

I authorize my employer to make any necessary payroll deductions and also declare that any disability coverage in force and applied for, with respect to myself, is less than 75% of my current monthly earnings (60% for intermediate disability income [redacted]

EMPLOYEE SIGNATURE _____ **DATE** 4-23-18

EMPLOYER SIGNATURE/VERIFICATION _____ **DATE** _____

[redacted]

Rev. 11/2015